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ABSTRACT

This paper describes a project which is attempting to strengthen existing mental health programs and develop new forms of support for rural children, since current programs are limited by a scarcity of funds, trained personnel, and supportive services. The setting of the project is a three-county area in Southwestern Pennsylvania which has been designated as "undersaved" in respect to health and mental health facilities. The paper describes the collaborative efforts of mental health professionals from a large urban university and a network of rural human service agencies, through which consultative and educational services as well as program development and evaluation are being provided. An important aspect of the work is to train Child Development Specialists who live and work in the three-county area. The paper describes the orientation, training, and professional responsibilities of these Developmental Specialists and documents the evolution of this new professional role. The activities initiated by the Developmental Specialists and the progress made in implementing this project can serve as a model for the creation of similar projects involving collaborative endeavors between mental health professionals from urban and rural areas. (Author)

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The development of a collaborative project between urban and rural mental health professionals

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Abstract

The development of a collaborative project between urban and rural mental health professionals

Mental health services for children in rural areas are limited by a scarcity of funds, trained personnel, and supportive services. This paper describes a project* which is attempting to strengthen existing programs and develop new forms of support for rural children. The setting of the project is a three-county area in Southwestern Pennsylvania which has been designated as "underserved" in respect to health and mental health facilities. Through the collaborative efforts of mental health professionals from a large urban university and a network of rural human service agencies, we are providing consultative and educational services as well as program development and evaluation.

An important aspect of our work has been to train Child Development Specialists who will live and work in the three-county area. This paper describes the orientation, training, and professional responsibilities of these Developmental Specialists and documents the evolution of this new professional role. The activities initiated by the Developmental Specialists and the progress we have made in implementing this project can serve as a model for the creation of similar projects involving collaborative endeavors between mental health professionals from urban and rural areas.

*Appalachia Regional Commission Grant #A4264646 B - Child Development Casualties: Identification and Remediation.

The development of a collaborative project between urban and rural mental health professionals

American's rural population is especially vulnerable to the stresses associated with geographic isolation, poverty, personal crisis and disruption of traditional lifestyles. The Preliminary Report of the President's Commission on Mental Health emphasized the Mental Health problems in rural areas and acknowledged that "the prevalence of serious emotional disorders in rural areas generally parallels that of urban areas, but people who live in rural areas have fewer mental health facilities and trained manpower to assist them." This statement is especially true of many portions of Appalachia. Various studies have described some of the efforts to provide health and mental health services to families in Appalachia. One could cite the work of David Looff who identified the characteristics of children and families in rural isolated areas of Eastern Kentucky and developed mental health services which were accessible and appropriate to their needs. Or Norman Polansky, who described the frustrating and often futile struggle of mountain folk to obtain adequate health care. Or Coleman and his colleagues at the University of Kentucky, who have presented a vivid picture of "mountain families in poverty" and the systems of support that are available to them.

In recent years, innovative mental health programs have been developed in many regions of Appalachia, particularly in the central and southern highlands. Various training programs have been designed to extend existing resources and alleviate the shortage of mental health workers. In some areas, the utilization of visiting consultants and educators has helped to strengthen the administrative and treatment capabilities of rural facilities. Most of these programs are located in the central and southern highlands.

Although the needs of rural communities in northern Appalachia are as great as those in the south, comparatively few facilities have been developed in the northern regions. I would like to describe one such project, in which we have attempted to create a model for effective collaboration between a Psychiatry Department in a major urban university and a network of rural community agencies in Pennsylvania Appalachia.

The Department of Psychiatry at the University of Pittsburgh has received a three year grant from the Appalachian Regional Commission for the purpose of implementing a project entitled "Child Development Casualities: Identification and Remediation." The State Department of Welfare had encouraged the project from its inception. The setting of the project is a three county area in southwestern Pennsylvania which has been designated as "underserved" in respect to health and mental health facilities. Services for young children and their families are especially scarce. There are only 12 pediatricians and a sprinkling of child psychiatrists and psychologists serving the entire population which, according to the 1970 census, includes approximately 36,000 children under the age of six. Acknowledging the complex needs of the area, the scarcity of consultation services and the hardships imposed by limited funds and few resources for staff training, the Appalachia Child Development Project has initiated a multi-faceted approach to meet some of these needs.

As the title of the project indicates, our work is directed to the identification of developmental delays and problematic behavior in young children under the age of six. Through various collaborative endeavors with the human services organizations who serve these children, the project staff is attempting to strenghten existing programs and develop new forms of intervention for the children and their families.

The Project's core staff consists of a child psychiatrist who is Project Director, a developmental psychologist, a public health specialist, and a part-time clinical child psychologist. These staff members are attached to the Office of Education and Regional Programming in the Department of Psychiatry at the University of Pittsburgh. This Office is responsible for providing a wide range of services to a 27-county area in Western Pennsylvania. The Appalachia Project, through its work in three of these counties, is fulfilling part of this responsibility.

During the initial planning stage of the Project, the Director held a series of meetings with representatives of the entire human service network in the three county area. In these preliminary meetings, the mandates and existing services of the agencies were reviewed. It became apparent that their resources in respect to services for children were seriously limited. Staff members generally lacked knowledge of basic issues in child development, nor had they been trained to work directly with children. We agreed that a way should be found, not only to improve the quality and quantity of services, but also to stimulate a greater interest and sensitivity to the needs of children, in the communities as well as in the agencies. It was decided that the best way to accomplish this would be to create a new professional role, a specialist in child development and community service. One of the early tasks of the Project was to identify the parameters of such a specialty recruit the appropriate persons to be trained, and develop a program for them. In planning this aspect of the Project, it was important to maximize the participation of available University staff and take full advantage of the resources of a major University Health Center. The plan would also take into consideration the limited duration of the project and the need to insure the continuation of services after the end of the three year period.

From the beginning, we secured the cooperation and active participation of the Directors of the Base Service Units in each of the four catchment areas in the three counties. They agreed that a new professional role in the form of a Child Development Specialist would be a valuable asset to their staff. Upon the recommendations of the Base Service Unit Directors, four persons were recruited for training, each of whom lives in one of the Base Service Unit catchment areas. It was agreed that these persons would be employed by the Project during its three year duration, after which they will become regular staff members of the Base Service Units.

The formal work of the Project began in the fall of 1976, when the core staff and the Developmental Specialist trainees were recruited. We initiated a series of meetings with all of the county agencies who serve young children. During this period, as we became familiar with the structure of each of the communities, it was important to keep in mind that we were, in a very real sense, foreigners. We were entering communities that had their own unique configuration, their own personalities, and their own perceptions of our staff of middle-class mental health professionals from a large urban university. We were entering a "world of predecessors," as Max Weber would have said, which included a political hierarchy, a cultural heritage, an economic history, and an existing network of human service organizations. One of our tasks was to relate in a coherent way to this context. Before the end of the winter, we had established contacts with more than 50 of these agencies, and had worked out preliminary plans for various kinds of consultation and educational services. During this period, the training of the Developmental Specialists was also initiated.

Their first year of training consisted of an intensive orientation to theoretical and practical issues relating to child development, family

life and community mental health. This was accomplished through a series of seminars and discussions with the core staff, interviews with parents, home visits, observations of children, and selected reading assignments. In addition, they were given an equally intensive orientation to the human service network in the three county area. They attended all the planning meetings and consultations with us and they prepared written reports of these meetings. They were introduced, in gradual stages, to the staff of the respective Base Service Units, as well as to the administrative structure, funding process, and scope of services provided in the catchment areas.

In addition to this very full schedule, the trainees were assigned to certain University of Pittsburgh Health Center facilities for one day each week in three month blocks. These placements included the Speech Clinic and Developmental Clinic at Children's Hospital, the Parental Stress Center, a rehabilitation program for abused children and abusive parents, and a special Head Start Center for disturbed children. These assignments were intended to familiarize the Developmental Specialists with the specialized diagnostic techniques and treatment facilities that are available at the health center, and to introduce them to some of the referral sources they may eventually wish to utilize.

By the end of the first year of the Project, we had developed a service delivery plan in each of the four catchment areas. We had completed the first phase of training with the Developmental Specialists, and had carved out an identity for ourselves, in the eyes of some of our university based colleagues, as a rather suspect group of roving do-gooders. We think we also built up a sense of credibility and trust among many of our colleagues in the counties when they realized that we usually managed to appear for our appointments, even in bad weather, and that we would continue to schedule our meetings in the counties where they live and work, instead of insisting that they come to us in the city.

We are now in the middle of the second year of the Project. For the Developmental Specialists, this has been a time of increasing autonomy and individual growth. Since September, 1977, they have been assigned four days per week to their respective Base Service Units. They have participated with us in ongoing Project services and have initiated and implemented various services on their own. They have gradually begun to be accepted by the Base Service Unit staff and integrated into the framework of the communities. We have found that each catchment area has its own unique needs and its own individual personality, so each of the Developmental Specialists finds herself with corresponding challenges and responsibilities. Because the scope of the project is so complex, I would like to summarize some of the areas of our work and describe how the Developmental Specialists contribute to it.

(1) Data Collection

One member of our core staff has collected and organized a considerable amount of data from the agencies and from the communities in these three counties. The Developmental Specialists are assisting with this ongoing data collection, which serves as the basis for our work in identifying demographic patterns, in planning services and research, and in providing the agencies themselves with more coherent information.

(2) Consultation and education services.

We have initiated a variety of consultations with a wide range of agencies including Child Welfare, Day Care services, centers for handicapped children, public health nurses, and the Base Service Units. We provide case consultations as well as administrative consultations, program development, and in some cases, program evaluation. We are also contributing to staff training by introducing and demonstrating various assessment techniques and by presenting seminars on various issues relating to child development.

Recently, we have begun a new series of inter-agency meetings. In each catchment area, we have recruited one or two representatives from each of the major agencies. We age giving a series of seminars on developmental interviewing, intake procedures, and developmental assessment. The response has been enthusiastic. We can anticipate that these seminars will have multiple benefits: Not only will they extend the capabilities of individual agencies and staff members in the agencies, but they alwo will facilitate a consistent method for data collection and provide the opportunity for interagency communication and collaboration. The Developmental Specialists are assisting in scheduling these meetings, in arranging for individual practicum assignments and supervision some of the developmental interviewing.

(3) Additional Activities

In addition to these services, we have undertaken a variety of other activities, including the development of parent education and Parents Anonymous groups, SCAN, or interdisciplinary meetings on child abuse, community education programs, and most recently, we have created an Executive Child Advocacy Committee in each of the catchment areas, which we hope will eventually assume the responsibility for planning and coordinating community services to children.

During the third year of the Project, we will be consolidating our activities, concentrating on those aspects which will insure continuity of our efforts. The Developmental Specialists will be assigned full-time to their respective Base Service Units and we will continue our collaboration and supervision of their work. We hope also to begin to investigate in a formal way some of the research issues which have emerged during the course of our work. We are especially interested in the patterns of utilization of human services by rural families, and we have begun to investigate the impact of infant mortality on families and communities in rural areas.

This project has presented us with a great many challenges, numerous obstacles and frustrations, and more than a few satisfactions. One of the most welcome outcomes has been the discovery of related services and innovative projects which have been initiated by our colleagues in the three county area. This conference has given us the opportunity to gather together some of the separate strands of our work, and share some of the common themes and diverse approaches that each of us has taken.

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